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| **Policy Name:** | **Skin Breakdown Protocol** |

1. **Policy Statement**

To provide a standardized and consistent approach for assessing and maintaining skin integrity and preventing skin breakdown.

1. **Reason for Policy**

The goals of this protocol are that skin risk assessments, skin inspections and strategies for preventing skin breakdown will be implemented consistently for patients receiving care at Serenity Care Center

1. **Who Should Read This Policy**

Registered Nurses, Licensed Practical Nurses, Certified Nurse Assistants, Respiratory Therapists, Occupational Therapists, Physical Therapists

1. **Definitions**

Braden Scale: standardized tool for determining level of risk for pressure ulcer development in adult patients (ICSI, 2007).

1. **The Policy**

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| **Procedure** | **Rationale** |
| 1. Assess all patients for risk of skin breakdown using the Braden Scale 2. Upon admission or transfer to another unit 3. With every shift assessment 4. At significant changes in patient status | The condition of the skin is an indicator of the general health of the patient. |
| 1. Total Braden Scores and document score on the Braden Scale Form:  * At risk/mild risk: 16-28 * Moderate risk: 13-15 * High risk: 10-12 * Very high risk: < 9 | Each subscale is ranked from 1-4 and then totaled for a score out of 28. The lower the score the higher the risk. |
| 1. Assess for additional risk factors including:  * Previous history of skin breakdown or pressure ulcers * Existing skin breakdown or pressure ulcer * Poor soft tissue coverage | Additional risk factors put the patient at higher risk for developing skin breakdown or pressure ulcers. |
| 1. Complete a head-to-toe skin inspection on all patients every shift and as needed. 2. Inspect and palpate for:   o alterations in skin moisture  o changes in texture, turgor  o change in temperature from surrounding skin (warmer or cooler)  o color changes (pale, red, purplish hues)  o non-blanching erythema  o consistency (bogginess or induration)  o edema  o open areas, blisters, rash, drainage  Observe skin in good lighting and palpate any areas of discoloration or redness for change in temperature compared to surrounding skin, or feeling of bogginess (soft) or induration (hard). Pay particular attention to areas over bony prominences.  NOTE: for darkly pigmented skin, look for purplish/bluish localized areas or localized warm areas that become cool. | Blanching erythema is an early indicator of the need to redistribute pressure.  Non-blanching erythema suggests that tissue damage has already occurred or is imminent. Indurated (hard) or boggy (soft) skin is a sign that deep tissue damage has likely occurred. |
| 1. Implement Braden Scale Interventions as appropriate, based on risk assessment scores and skin inspection   At Risk/Mild Risk or Moderate Risk:   * Offer toileting as needed * Reposition every 2 hours or as needed * Inspect skin when repositioning, toileting, & assisting with ADLs * Provide routine skin care and moisturize skin daily * Develop and document individualized care plan   High Risk to Very High Risk:   * Reposition every 2 hours * Use heel protectors and elevate heels off the bed at all times * Use pillows or foam wedges to avoid pressure on bony prominences * Limit sitting to 1-2 hour intervals * Collaborate with PT/OT and Wound Care Nurse * Develop and document individualized care plan * Document repositioning every 2 hours and document interventions used each shift or as needed |  |